MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes () No
Requestor's Name and Address AHC on behalf of Southwest Texas Methodist Hospital C/O Thompson Coe 701 Brazos, Suite 1500 Austin Centre Austin, Texas 78701	MDR Tracking No.: M4-04-1560-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address TML Intergovernmental Risk Pool 1821 Rutherford Lane, Suite 100 Austin, Texas 78754-5163 Box 19	Date of Injury: Employer's Name: City of Cotulla Insurance Carrier's No.: T070000051989

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
04/01/03	**04/05/03**	**Hospital Admission**	**$34,149.28**	**$34,149.28**

PART III: REQUESTOR'S POSITION SUMMARY

"The Patient's claim met stop-loss, with total charges of $78,368.39. The stop-loss payment that should have been paid to my client is $58,762.79. Carrier paid $24,613.51, under the rules and regulations of the commission, this payment is incorrect. Carrier still owes an additional amount of $34,149.28."

PART IV: RESPONDENT'S POSITION SUMMARY

"The claimant had a four day hospital stay for a lumbar fusion. This medical dispute is a stop-loss case involving DOS 4/5/03. Carrier paid $24,613.51 of a bill for $78,368.39 leaving $34,149.28 in dispute. Requestor demands payment for 75% of total charges, but has not shown entitlement to this alternative, exceptional method of calculating reimbursement and has not otherwise properly calculated the audited charges."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested additional reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed $40,000 in total audited charges, but also involve "unusually extensive services."

After reviewing the information provided by both parties, it does **not** appear that this particular admission involved "unusually extensive services." Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem methodology described in the same rule. The requestor indicates in the operative report, that this was a posterior lumbar fusion. The patient tolerated the procedure well was taken to the recovery room in good condition and no complications were noted in the operative report.

The carrier made reimbursement based on per diem for the 4-day stay in the amount of $4,472.00. The carrier also reimbursed the requestor an additional amount of $20,141.51 for the implantables and other services bringing the total amount of reimbursement to $24,613.51. The provider billed $56,939.00 for the implantables. The provider submitted invoices totaling $50,202.93 in billed amount, so using the invoice amount at cost plus ten percent = $55,223.22 ($50,202.93 x 10% = $55,223.22). The total amount of per diem ($4,472.00) plus cost plus ten percent ($55,223.22) = $59,695.22 minus what carrier already paid $24,613.51 equals $35,081.71.

However, the requestor has indicated that the amount in dispute per the TWCC-60 Table of Disputed Services is $34,149.28. Therefore, additional reimbursement in the amount of $34,149.28 is recommended.

Therefore, based on the facts of this situation, the parties' positions, and the application of the provisions of Rule 134.401(c), we find that the health care provider is entitled to additional reimbursement of $34,149.28.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor **is** entitled to additional reimbursement in the amount of $34,149.28. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20 days of this Order.

Ordered by:

	Allen McDonald	06/15/05
Authorized Signature	Typed Name	Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787 Austin, Texas 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____